# TRICARE LATIN AMERICA & CANADA (TLAC) PRIME ENROLLMENT APPLICATION (Latin America & Canada Remote)

## SPONSOR INFORMATION

CAN BE COMPLETED BY ANY ADULT BENEFICIARY. SEE REVERSE FOR DIRECTIONS. PLEASE PRINT CLEARLY.

| 1. Sponsor Name (last, first, middle initial) | 2. Sponsor Social Security Number | 3. Sex | 4. Country & City Sponsor Residing in | 5. Date of Birth | 6. Rank | 7. Telephone Numbers |
|---|---|---|---|---|---|---|
| | | | | | | Duty: |
| | | | | | | Home: |

| 8. Duty Address (Unit, Office Symbol, Station, APO/FPO, (Country) | 9. DEROS/PRD (*required*) | 10. Mailing Address (Box Number, APO/FPO, Zip Code) | 11. Sponsor Status (Must be Active Duty) | | |
|---|---|---|---|---|---|
| | | | Army | Air Force | Navy |
| | | | Marines | USCG | NOAA/PHS |

| 12. E-Mail Address (if exists) | 13. Primary Care Manager (PCM) Selection |
|---|---|
| | **ISOS PCM CALL CENTER** |

**LIST ALL FAMILY MEMBERS ACCOMPANYING THE SERVICE MEMBER TO LATIN AMERICA OR CANADA AND ARE APPLYING FOR ENROLLMENT.**

**PLEASE PRINT CLEARLY**

| 14. Family Member Name (last, first, middle initial) | 15. Family Member Social Security Number | 16. Sex ( M or F) | 17. Relationship to Sponsor | 18. Date of Birth (dd/mmm/yyyy) | 19. Country & City Currently Residing In |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**20. SIGNATURE:** "I have read the instructions on the reverse side of this form and understand the Privacy Act Statement listed there. I further request enrollment for my listed family members in TRICARE Latin America & Canada Prime."

SIGNATURE DATE



(Rev. Jan 2005) **Please return this completed application to TLAC Support Office ALONG WITH A COPY OF YOUR ORDERS (details on back)**

# INSTRUCTIONS

1. SPONSOR NAME: Last name, first name, middle initial.
2. SPONSOR SOCIAL SECURITY NUMBER: This is the SSN of the active duty member
3. SEX: M or F.
4. SPONSOR RESIDING IN: Country & City in which sponsor is stationed.
5. DATE OF BIRTH: Enter DOB of sponsor. List by dd/mmm/yyyy (example: 11 Oct 1962).
6. RANK: List rank of sponsor (not pay grade). (example: Army 0-4 should be MAJ).
7. TELEPHONE NUMBER: Sponsor's work & enrollee home phone numbers including country code, (complete phone number if dialing from the US).
8. DUTY ADDRESS: Please list Unit, Office Symbol, Installation, APO/FPO, Zip Code.
9. DEROS/PRD: Enter the sponsor's date of estimated return from overseas/projected rotation date.
10. MAILING ADDRESS: This is the mailing address where you and/or the requested enrollees currently reside: Include Box Number, APO and Zip Code.
11. SPONSOR BRANCH OF SERVICE: Circle the appropriate selection.

    Note: **Only Active Duty and their accompanying family members are authorized to enroll in TLAC Prime.**
12. E-MAIL ADDRESS: Please provide if one exists for work, home or both. (This will provide another avenue for important medical benefit information to be distributed)
13. PRIMARY CARE MANAGER (PCM) SELECTION.

- For Canada, enter the nearest Canadian Forces Health Facility or city.
- In most other cases, TLAC beneficiaries will have a American Embassy PCM. Enter "US Embassy" followed by the country, i.e. "US Embassy Brazil".
- If you have any questions please contact the TLAC Area Office.

14. FAMILY MEMBER NAME: List each family member (last name, first name, middle initial) who is residing in Latin America or Canada.
15. FAMILY MEMBER SOCIAL SECURITY NUMBER: Please list the Social Security Numbers for each family member. If the family member has not yet been issued a SSN, or if you do not know the number, please write that in this section.
16. SEX: Please enter the Family Member's Sex (M for male or F for female)
17. RELATIONSHIP TO SPONSOR: Please enter the appropriate response using the samples below (For questions please contact the TLAC Support Office)
    - SPOUSE
    - DAUGHTER
    - SON

    **** IF SPOUSE IS ALSO ON ACTIVE DUTY, PLEASE INDICATE IT IN THIS BLOCK****
18. DATE OF BIRTH: List the date of birth for each family member. (dd/mmm/yyyy)
19. Country & City Currently Residing In.
20. SIGNATURE: Either adult beneficiary must sign and date the form. The signature of the sponsor or the sponsor's spouse is required.

Mail completed form along with a copy of the **sponsor's orders** to:

TRICARE Area Office
(Latin America & Canada)
TLAC – B38802 (Enrollment)
Fort Gordon, GA 30905-5650

OR FAX completed form along with a copy of the **sponsor's orders** to 706.787.3024 (DSN 773)

OR E-mail completed form along with a copy of the **sponsor's orders** (as attached file) to tricare15@se.amedd.army.mil



PRIVACY ACT STATEMENT

AUTHORITY: Title 10, USC, Sec. 1095 and 1099; EO 9397

| | |
|---|---|
| PRINCIPAL PURPOSE(S): | Information will be used to enroll the beneficiary(ies) in TRICARE Latin America & Canada Prime, and to assign Primary Care Managers (PCMs) to each enrollee. Information will also be used by military treatment facility (MTF) staff and TRICARE contractors to determine eligibility for care and payment of claims. |
| ROUTINE USE(S): | The information on this form will be released to the MTF staff, TRICARE contractors, and providers of health care. |
| DISCLOSURE: | Is voluntary, however, failure to provide the information requested may preclude your enrollment in TRICARE Latin America & Canada Prime. |